THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016896
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 565

1. PLACE OF DEATH
a. COUNTY: BUCHANAN
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Missouri Methodist Hospital — Length of stay in 1b: 13 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: ANDREW
CITY OR TOWN: SAVANNAH — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 410 North 3rd — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: COMBS Last: WRIGHT

4. DATE OF DEATH: Month: May Day: 25 Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: Dec. 5, 1877

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired nightwatchman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Andrew County, Mo.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Wright

13b. MOTHER'S MAIDEN NAME: Ellen Welch

14. NAME OF HUSBAND OR WIFE: Hallie Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: - - - -

17. INFORMANT Address: Mrs. Josephine Steele, Denver, Colo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio-sclerotic heart disease with congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arterio-sclerotic gangrene of left foot 4200

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5-12-53 to 5-25-59 and last saw him alive on 5-25-59
Death occurred at 2:10 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Warren C. Baker M.D.

22b. ADDRESS: Savannah, Missouri

22c. DATE SIGNED: 5-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: May 25, 1959

23c. NAME OF CEMETERY OR CREMATORY: Savannah Cemetery

23d. LOCATION (City, town, or county) (State): Savannah, Missouri

24. FUNERAL DIRECTOR ADDRESS: Breit Funeral Home, Savannah

25. DATE RECD. BY LOCAL REG.: May 28 1959

26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

Dr. Warren C. Baker

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed James P. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.